MEDICAID DRUG PROGRAM

FINDING: Drug Costs are a major reason that Medicaid payments are rising, but the state has few effective tools to deal with the rising cost or usage of prescription drugs.

Payments for prescription drugs are a large and rapidly escalating cost in the Medicaid program. Medicaid expenditures for prescription drugs in 99-00 were $452 million for some 11.33 million prescriptions. Rebates form the National Medicaid Rebate Program were about 19% of this amount, or $85 million. This reduced the net prescription drug cost to some $367 million.

Medicaid drug expenditures have averaged a 3.1% growth annually since 1996-97. National research shows that there are several factors contributing to this cost increase. These include:

- New, more expensive drugs coming to market more quickly
- More extensive use of drugs for a wider variety of conditions
- High inflationary price increase, particularly in the spring of 1998

Rapidly rising drug expenditures have propelled prescription drugs to the third largest Medicaid expenditure for 2000-01. DHH projects that drug spending could double by 04-05, which will make it the largest single expenditure category of the Medicaid program. There is some evidence that increased drug usage will reduce long-term cost of other health care services, such as hospitalization. However, these savings have not been quick to show up in other health care expenditures.

Prescription drug coverage is among the broadest of Medicaid programs in terms of utilization. 1998-00 data show that over 578,000 or about 80% of all Medicaid clients used prescription drugs that year. Only physician's services are accessed by a larger number of Medicaid clients.

DHH data show that, despite the escalation of total pharmacy spending, drug costs per person in Louisiana have grown less than in other states. In 1993, Louisiana ranked eighth in drug costs per Medicaid eligible; in 1998, it ranked 40th. DHH credits this decline to effective management, including policies that: establish maximum allowable costs for multi-source drugs; encourage generic substitution when possible; provide most-favored customer rates on dispensing fees; and provide some point-of-sale oversight of excessive drug use (PRO-DUR).

<u>OPTION 1</u>: *Open Drug Formulary* – In order to evaluate cost savings and benefits that could be realized through prior authorization of drugs, DHH should prepare proposed policies, procedures, and fiscal impacts for its prior authorization proposal. DHH should also prepare an assessment of how prior authorization may affect clients and retail pharmacists, including any health care outcome effects.

Description and Background: DHH stated that it needs greater statutory flexibility to manage Medicaid drug costs. Since 1989, the Medicaid Open Formulary law (R.S. 46:153.3(B)(3)) has required Medicaid to pay for any FDA-approved drug prescribed to a Medicaid client. Since 1991, our ability to restrict drugs that Medicaid must cover also has been affected by the National Rebate Program. DHH also stated that excluding certain drugs from the Medicaid Formulary could jeopardize participation in the National Rebate Program.

However, DHH believes that the state open formulary law also ahs kept DHH from using cost-constraining tools used succe3ssfully in other states. Examples include prior authorization and payment only for particular drugs in a therapeutic category. Other states have implemented such restrictions without losing participation in the National Rebate Program. DHH attempted to obtain statutory changes to allow prior authorization of certain drugs in 1999, and it indicated it would again propose such legislation in 2001.

Drug manufacturing and retail pharmacy representatives testified against a restrictive drug formulary. They stated that such actions had not been cost-effective in other states and would drive up other health care costs. Retail pharmacy spokesmen indicated that administering such a program could be costly and crate problems for providing drugs in some cases.

Estimated Fiscal Impact: The savings from formulary restrictions will depend on the extent to which restrictions occur.

Action Required to Implement: Statutory change to the open formulary law.

OPTION 2: ***Retail Pharmacy Reimbursement for Drugs*** **- The committee recognized that retail pharmacies are not the primary cause of increasing drug costs. It urges DHH not to continue reducing reimbursements to retail pharmacists.** However, the committee made no recommendations concerning the two-tiered reimbursement system, the dispensing fee, or the co-payment.

Description and Background: In June, 2000, DHH implemented a permanent rule that reimburses drug costs to chain pharmacies (11 or more stores) at a lower price than the reimbursement to independent pharmacies. This rule reflected the results of a cost study commissioned by DHH in 1999. Two companies, Walgreen's and Wal Mart, have sued DHH, alleging that the two-tiered reimbursement is illegal. DHH's position is that the lower rate for chain pharmacies is justified by the chain's lower drug acquisition costs, as document in its cost study. It believes that its actions regarding the drug costs reimbursement are reasonable and it expects to defend its actions in court.

DHH also reimburses pharmacists with a dispensing fee for each prescription. The maximum fee is $5.77, but pharmacists may not charge more than their "usual and customary" charge. Consequently, Medicaid generally pays less than the maximum fee $5.77. IN 199-00, the dispensing fee averaged only about $4.42 per prescription.

Pharmacy manufacturer representatives did not testify on the retail payment issue. Chain retail pharmacy spokesmen stated that there was no evidence of lower acquisitions costs for chain pharmacies that would justify the two-tiered reimbursement. Small retail pharmacy spokesmen also stated that the reimbursement rate was too low generally. They also testified that many pharmacies have difficulty collecting the co-payment from the Medicaid client. This fee, which rises from $.50 to $3.00 with the prescription costs, is deducted from the Medicaid payment. However, the pharmacy may not refuse to fill the prescription if the client cannot pay the co-payment. According to retail pharmacy spokesmen, uncollected co-payments are a significant loss to the industry.

Estimated Fiscal Impact: Not applicable.

Action Required to Implement: Not applicable unless the Legislature wishes to communicate specific instructions to DHH via a resolution or Appropriations Act amendment.

OPTION 3: ***Drug Rebates and Bulk-purchase*** **- DHH should pursue additional rebates in those instances where they are cost effective. If prior authorization were to receive legislative approval, DHH should provide for waiver of this requirement if manufacturers agree to additional rebates of at least 5% greater than the National Rebate Program.**

Description and Background: Several committee members expressed interest in how the state could obtain lower prices for drugs without reducing further the amounts paid to retail pharmacies. The two methods discussed were bulk purchases of drugs and additional rebates from drug manufacturers.

DHH testified that bulk purchase agreements would be likely to void the rebates received under the National Rebate Program. Staff inquiry of other states that had used or investigated bulk purchases confirmed that drugs obtained through bulk-purchase programs generally do not qualify for the manufacturer's rebate.

Drug manufacture representatives testified that under the National Rebate Program, states get the “best price” wit the exception of two classes of trade – the U.S. veteran’s affairs and the federal supply schedule purchases. The rebates for single source drugs are a minimum of 15.1% plus additional amounts if prices exceed inflation. The rebate for generic drugs is 11% and there is not inflation adjustment. Spokesmen for drug manufacturers did say that rebates on generic drugs equivalent to rebates on brand name drugs could produce as much as $8-$10 million in additional rebates.

Staff research shows that federal law permits additional rebates, and that other states do negotiate additional rebates from drug manufacturers. Florida has recently passed legislation authorizing its Medicaid agency to negotiate bigger rebates on generic drugs, and California has negotiated additional rebates on single source drugs for several years. California rebate agreements include prices paid by veteran’s affairs and the federal supply schedule in determining the “best price” for rebate calculations.

Information from HCFA suggests that states often relax formulary restrictions, such as prior authorization, for companies that agree to additional rebates. This is specifically the case in California, which requires prior authorization of all drugs that do not have state rebate agreements.

Estimated Fiscal Impact: Data on the savings from such state-negotiated rebates is limited. California Medicaid officials indicate that the additional savings (over the National Rebate Program) is about 5%. The fiscal analysis of Florida's legislation for generic rebates indicated that savings would be about $2 million. Florida's drug program is roughly three times the size of the Louisiana drug program.

DHH drug utilization confirms that the savings from additional rebates on generic drugs would be relatively small (about $1 million at a 15.1% rate). Additional rebates on single source drugs would be more significant, and would increase the rebate by about $3 million for each additional percentage point of rebate.

Action Required to Implement: DHH can pursue such supplementary rebates on its own initiative. However, the legislature may wish to instruct it to do so through legislation.

<u>OPTION 4</u>: ***Generic Drugs*** **- DHH should consider additional provider and Medicaid client incentives to encourage more generic drug use, including:**

- Lower co-payments for generic drugs
- Better reimbursement rates for generic drugs
- Physician education about generic substitution
- Expanded electronic therapeutic authorization

Description and Background: Testimony indicated that there were some problems with using more expensive brand name drugs when less expensive generic equivalents were available. This problem is not largely due to the use of maximum allowable cost pricing and generic substitution by pharmacists. However, there are still a significant number of instances where generics are not used, although they could be.

Estimated Fiscal Impact: Cannot be determined.

Action Required to Implement: Agency rule making or statutory change.

<u>OPTION 5</u>: ***Other Issues*** **- Require DHH to activate the various boards and committees involved in setting Medicaid drug policies and solicit their input on cost saving measures.**

Description and Background: Testimony by retail pharmacists and others indicated that other administrative actions could also help control Medicaid drug costs. These included:

- Reactivation of the Pharmacy Interdisciplinary Advisory Committee
- Better use of disease state management by physicians
- Expand drug utilization review and expansion of electronic therapeutic authorization

Estimated Fiscal Impact: Cannot be determined.

Action Required to Implement: Action by DHH to activate committees and review groups.